

TOWN/CITY OF _____
BENEFIT DATA INFORMATION SHEET
ANDROSCOGGIN COUNTY

Date: _____

CDBG PROGRAM TYPE _____

The Town/City of _____ is currently preparing an application for Community Development Block Grant (CDBG) funds from the State of Maine, Department of Economic and Community Development. The proposed activities are to: _____

For the proposed activities, the CDBG program requires proof of providing benefit to low and moderate-income persons. Therefore, the community is surveying the potential beneficiaries to ensure compliance with the regulations of the CDBG Program.

Your response to the following questions is critical in finalizing the application process. All responses will be kept confidential and used solely for securing CDBG grant funds.

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Name (optional): _____

Survey # _____

Address: _____

Please place an "X" in the appropriate spaces pertaining to your family's size, annual income and makeup.

<u>FAMILY SIZE</u>		<u>INCOME</u>	
1	\$28,550	Above _____	Below _____
2	32,650	Above _____	Below _____
3	36,700	Above _____	Below _____
4	40,800	Above _____	Below _____
5	44,050	Above _____	Below _____
6	47,350	Above _____	Below _____
7	50,600	Above _____	Below _____
8	53,850	Above _____	Below _____

Read This Carefully

In determining total family income use your Total Adjusted Gross income for your household as reported on your most recent Federal Income Tax form.
If you use Form 1040 – use line 35
If you use Form 1040A – use line 21
If you use Form 1040EZ – use line 4

BENEFICIARY INFORMATION:

Family Race indicate by putting an "X" on the appropriate line

White _____ Black/African American _____ Asian _____ American Indian/Alaskan Native _____
Native Hawaiian/Other Pacific Islander _____ American Indian/Alaskan Native & White _____
Asian & White _____ Black/African American & White _____
American Indian/Alaskan Native & Black/African American _____ Other _____

Family Make-up: Enter number of elderly or severely disabled family members and indicate with an "X" if a female head of household is present

Number of Elderly: _____

Number of Severely Disabled: _____

Female Head of Household?: _____ Yes _____ No

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TO BE FILLED OUT BY INDEPENDENT VERIFIER: LMI _____ NON-LMI _____

Signature of authorized official

Date